Māori Health Review

Making Education Easy

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In this issue:

Tēnā koutou, tēnā koutou, tēnā tātou katoa

Nau mai ki tenei Tirohanga hou Hauora Māori. He rangahau tuhi hou e paa ana ki nga hauora a ki te oratanga o te Māori.
He tirohanga wehe poto o etahi o nga rangahau o te waa kainga me te take o te tino hirahira o nga tuhituhi.
E hari koa ana mātou mo te tautoko o te Te Kete Hauora me nga Manatū Hauora mo to rātou whakāri putanga.
He mihi ki ia tātou katoa e mahi ana i waenganui i te Māori ki te tono mai ētahi whakatakotoranga a ma mātou o koutou rangahau e tirohia.
No reira noho ora mai rā i o koutou wāhi noho a wāhi mahi hoki.
Matire

Greetings

Welcome to Māori Health Review, an independent summary of some of the significant and relevant recently published/presented research with a local commentary. We are delighted to have support from the Ministry of Health with the bi-monthly editions and welcome submissions from Māori health providers and researchers for consideration in future issues.
All the best to you in your work and with your whānau.

Matire

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Health-related quality of life among adults who experienced maltreatment during childhood

Authors: Corso PS et al

Summary: A total of 2812 adults who reported childhood maltreatment were matched with 3356 adults who reported no childhood maltreatment, and compared using propensity score methods. Health-related quality-of-life data (or "utilities") were imputed from the Medical Outcomes Study 36-Item Short Form Health Survey using the Short Form–6D preference-based scoring algorithm. The combined strata-level effects of maltreatment on Short Form–6D utility was a reduction of 0.028 per year ($p<0.001$). All utility losses differed significantly between the two groups by age level: 18–39 years, $p<0.042$; 40–49 years, $p<0.038$; 50–59 years, $p<0.023$; 60–69 years, $p<0.016$; ≥70 years, $p<0.025$.

Comment: Although there may be issues with validity (including recall bias) and definitions ('maltreatment' for example), the results from this study are significant – child maltreatment has a sustained negative impact on health-related quality of life. As the UN Committee on The Rights of the Child has stated, children have the right to be brought up without the use of force including physical punishment, the causing of psychological harm and other degrading measures. The results from this and similar studies have major implications for the prevention of child abuse/neglect, particularly as part of an education programme.

Reference: Am J Public Health. 2008;98:1094-100
http://dx.doi.org/10.2105/AJPH.2007.119826

Tackling health inequalities: moving theory to action

Authors: Signal L et al

Summary: This paper reports on a series of awareness-raising workshops that aimed to increase the knowledge and skills of New Zealand health sector staff to act on, and advocate for, eliminating inequalities in health. Participants identified a range of institutional mechanisms that promote inequalities and a range of ways to address them including: undertaking further training, using Māori (the indigenous people) models of health in policy-making, increasing Māori participation and partnership in decision making, strengthening sector relationships with iwi (tribes), funding and supporting services provided 'by Māori for Māori', ensuring a strategic approach to intersectoral work, encouraging stronger community involvement in the work of the institution, requiring all evaluations to assess impact on inequalities, and requiring the sector to report on progress in addressing health inequalities. Ninety percent of participants rated the workshop as valuable or better and all but two rated themselves as willing to take action following the workshops.

Comment: A 'must read' given the fact that leaders in Hauora Māori and the New Zealand health sector have contributed to this paper. I found the information about ways to assist in transferring knowledge of racism in health particularly useful.

Reference: Int J Equity Health. 2007;6:12

http://dx.doi.org/10.1186/1475-9276-6-12

Identification of diabetic complications among minority populations

Authors: Shen JJ and Washington EL

Summary: These researchers sought to better understand underlying causes of ethnic disparities relating to diabetes, by using data from the 2003 National Inpatient Sample to analyse the correlation between the primary diagnosis on patient admission and the likelihood that the condition represented poorly controlled diabetes or a diabetes-related complication. They found that minorities were more likely to be admitted through the emergency department and for a condition directly related to diabetes progression. Minorities were also more likely to be admitted for acute hyperglycaemia and acute hypoglycaemia.

Comment: Evidence that tackling root causes, particularly for a chronic condition such as diabetes, is required if we are to address ethnic disparities. Multiple factors at many sites along the care pathway were identified in this study. However, the authors have also described possible interventions to deal with many of these factors.

Reference: Ethn Dis. 2008;18:136–140

http://tinyurl.com/5hv8wl

Being poor and coping with stress: health behaviors and the risk of death

Authors: Krueger PM and Chang VW

Summary: Data from the 1990 National Health Interview Survey's Health Promotion and Disease Prevention Supplement, involving 40,335 US adults, were linked to prospective National Death Index mortality data through 1997, to determine whether smoking, alcohol use, and physical inactivity moderate the relationship between perceived stress and the risk of death in the US population as a whole and across socioeconomic strata. High baseline levels of former smoking and physical inactivity increased the impact of stress on mortality in the general population as well as among people with low socioeconomic status (SES), but not those with middle or high SES.

Comment: Common sense tells us that the negative effects of stress, deprivation and associated health behaviours on wellbeing are cumulative but here we have evidence to prove it. Any approach to anti-smoking and physical activity must have specific measures for people with increased risk (based on ethnicity and socioeconomic status) in order to reduce health inequalities.

Reference: Am J Public Health. 2008;98:889-96

http://dx.doi.org/10.2105/AJPH.2007.114454

Sleep problems

Authors: Paine S-J et al

Summary: In chapter 13 of Hauora: Māori Standards of Health IV, Sarah-Jane Paine, Ricci Harris and Kara Mihaere discuss sleep and sleep disorders in New Zealand. They highlight the fact that Māori are more likely to suffer from insomnia and obstructive sleep apnoea syndrome than non-Māori and that Māori have more risk factors for the development of sleep problems than non-Māori. The chapter acknowledges that disparities in sleep problems between Māori and non-Māori may impact on disparities in other health outcomes and the authors recommend that Māori needs are prioritised in the development, planning, and purchase of sleep services, which need to be appropriate and accessible to Māori. The chapter ends with a framework for understanding health inequities including the direct and indirect effects of racism.

Comment: As the authors of this chapter from Haoura: Māori Health Standards IV 2000–2005 state, the study of sleep and sleep disorders is a relatively new discipline in Aotearoa. And as such, there are currently limited services for the diagnosis and treatment of sleep-related problems. This chapter describes some of the more common sleep problems including obstructive sleep apnoea and insomnia and the ways in which these can impact on health.

http://www.hauora.maori.nz/downloads/hauora_chapter13_web.pdf

Inequity of access to investigation and effect on clinical outcomes: prognostic study of coronary angiography for suspected stable angina pectoris

Authors: Sekhri N et al

Summary: In this retrospective analysis, records were examined from 1375 patients attending six ambulatory care clinics in England who were appropriate candidates for investigation by coronary angiography, to determine whether they received the angiogram or not. Overall, 69% of patients deemed appropriate for angiography did not receive it. According to multivariate analyses, patients who were aged >64 years, were women, of south-Asian origin and were in the most deprived fifth of the population were less likely to receive coronary angiography than those who were aged <50 years, were men, were white, or were living in the other four fifths. Not undergoing angiography when it was deemed appropriate was associated with higher rates of coronary event.

Comment: Further evidence that the receipt of cardiac procedures is influenced by the age, gender, ethnicity and socioeconomic status of the patient presenting with acute coronary syndrome. The authors were not able to explain disparities, although they recognise that 'isms' and consequently privileging can occur at the system level, occur during the provider-patient interaction or are internalised. In order for services and clinicians to accept that 'isms' exist and identify strategies to eliminate these (and therefore improve health outcomes), open discussion is required.

Reference: BMJ. 2008;336:1058-61

http://dx.doi.org/10.1136/bmj.39534.571042.BE

Independent commentary by Dr Matire Harwood, Medical Research Institute of New Zealand

Varied routes of entry into secondary care and delays in the management of lung cancer in New Zealand

Authors: Stevens W et al

Summary: This study assessed data from an audit of secondary care management in Auckland-Northland of 565 lung cancer patients diagnosed in 2004, to determine entry routes into and transit times in secondary care. Most patients (198; 35%) entered secondary care via the emergency department (ED), especially those with metastatic disease. The median time from entry to diagnosis was 22 days overall, but only 11 days when entry occurred via ED. The median time from entry to treatment was 64 days; 59 days for palliative treatment and 76 days for curative treatment. Initiation of treatment within internationally recommended timeframes occurred for 41% patients undergoing surgical resection, 36% receiving definitive (56% palliative) radiation therapy and 40% receiving chemotherapy. In multivariate analysis, factors that influenced these times included the entry route, the presenting symptoms, the investigations performed, the tumour type, multidisciplinary discussion and Māori ethnicity.

Comment: Lung cancer care in NZ does not meet best practice guidelines, particularly in terms of time to treatment. Delays were associated with clinical factors (presenting symptoms, tumour type), service factors (timeliness and input from MDT), access and importantly, Māori ethnicity. Lung cancer is a leading cause of cancer and cancer deaths for Māori; attention to prevention and treatment of lung cancer in Māori is required.

Reference: Asia Pac J Clin Oncol. 2008;4:98-106

http://dx.doi.org/10.1111/j.1743-7563.2008.00158.x

Effect of installing effective heaters into the homes of asthmatic children

Authors: Viggers H et al

Summary: This randomised community trial involving 409 children from households in five communities in New Zealand investigated whether non-polluting, more effective home heating alleviates children's winter asthma symptoms and improves lung function. In the intervention group, a more effective non-polluting replacement heater was installed before winter in June 2006. Compared with the control group, indoor temperatures for the intervention group were higher by 1.09°C in the living room and by 0.57°C in the child's bedroom. The intervention group was exposed to low temperatures (number of hours per day by the number of degrees <10°C) in the living room for 1.13 degree hours, whereas the control group was exposed for 2.34 degree hours. Children in the intervention group had less poor health (adjusted odds ratio 0.44) and lower levels of lower respiratory symptoms (0.76) versus the control group. In addition, significantly fewer school days were missed in the intervention group versus the control group. Lung function did not differ between the groups, but after controlling for nitrogen dioxide levels in the home, the improvement in FEV1 was significant for the intervention group.

Comment: An important paper presented at the recent Australasian Public Health Conference in Queensland, given that:

1. A number of Māori communities were consulted prior to the study
2. Many whānau participated in the actual study
3. Asthma is a health priority for Māori given health need and He Korowai priorities.

http://www.populationhealthcongress.org.au/update02072008/PopulationHealthCongressAcceptedFullPaper.pdf

New Zealand smoking cessation guidelines

Authors: McRobbie H et al

Summary: Recommendations for New Zealand smoking cessation guidelines were formulated after a comprehensive literature review of smoking cessation interventions undertaken in November 2006. These guidelines are structured around a new memory aid (ABC) which incorporates and replaces the 5A's (ask, advise, assess, assist, arrange). Healthcare professionals are prompted to *ask* about smoking status; *briefly* advise all smokers to stop smoking; and offer smoking cessation support which includes both behavioural (e.g. telephone and face-to-face support) and pharmacological (e.g. nicotine replacement therapy, nortriptyline, bupropion, or varenicline) interventions. Recommendations were also formulated for priority populations of smokers: Māori, Pacific, pregnant women, and people with mental illness and other addictions.

Comment: Useful advice for doctors and nurses in primary through to tertiary care. More detailed information is available for those people providing cessation support programmes, particularly to Māori.

Reference: N Z Med J. 2008;121(1276):U3117

http://www.nzma.org.nz/journal/121-1276/3117/

Ethnic and socioeconomic inequalities in lung cancer in a New Zealand population

Authors: Sutherland TJ and Aitken D

Summary: This study determined the incidence of lung cancer, duration of survival and treatment according to ethnicity and socioeconomic status in a health district in New Zealand, using data from 102 patients diagnosed with lung cancer in the period 1997–1999. The incidence of lung cancer was 3–4 times higher among Māori compared with New Zealand Europeans, while patients from the more socially deprived areas had nearly double the incidence. More than one half of the patients presented with widespread disease; a disproportionate number of those were Māori and socially disadvantaged. Only 9.8% of cases were considered to be potentially curative. Survival at 1 year was 24% and at 5 years, 6%. No Māori were alive at 5 years.

Comment: This could be considered follow-up to a paper that was included in a previous Māori Health Review. Although survival from lung cancer for all patients at this regional hospital was low, the authors have highlighted the fact that it was zero for Māori at 5 years. A review of lung cancer care in other centres could perhaps uncover services or care pathways that work for Māori with lung cancer.

Reference: Respirology. 2008;13:590-3

http://dx.doi.org/10.1111/j.1440-1843.2008.01301.x